Disease Management

Outreach Toolkit

2014

MISSOURI DEPARTMENT OF MENTAL HEALTH

Project Overview

The Disease Management Project began as a a two year collaborative initiative in November, 2010 among the Department of Mental Health (DMH), MO HealthNet Division (MHD), and the Coalition of Community Mental Health Centers. The project targets high cost Medicaid recipients who have severe mental illness (SMI) and impactable chronic medical conditions. It is typically referenced as *DM 3700* because that was the target number of individuals in the first phase of implementation. The services and interventions provided to these individuals have reduced costs to the state for providing care and treatment and have greatly improved outcomes for the identified participants.

As a result of the success of the program, disease management was expanded in 2014 to individuals with high medical costs, chronic medical conditions, and substance use disorders (referenced as ADA Disease Management or *ADA DM)*. Providers contracted with DMH have agreed to contact these identified individuals, provide outreach and engagement, enroll them in the Community Psychiatric Rehabitation (CPR) Program and/or Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program, and provide necessary services with an emphasis on community support/case management to coordinate and manage their medical, psychiatric, and substance use conditions.

The Disease Management 3700 Policies and Procedures and other relevant information can be found on the DMH website: http://dmh.mo.gov/mentalillness/provider/DM3700.htm & http://dmh.mo.gov/mentalillness/provider/policymemos.htm

The ADA DM Policies and Procedures and other relevant information can be found on the DMH website: http://dmh.mo.gov/ada/provider/DiseaseManagement3700SubstanceUseDisorders.htm

‹ Outreach Toolkit ›

Building a Successful Outreach Team

*Building a successful outreach team is essential to achieving the goals of the Disease Management projects. Each behavioral health provider's **outreach team** is typically led by one or more DM project coordinators who have assumed responsibility for the project and participate in technical assistance calls and trainings with DMH.*

Here are some examples of how providers have built and staffed their teams:

- Outreach team(s) consist of the DM project coordinator(s), multiple community support staff (depending on how many consumers have been assigned to the provider), and one or more Qualified Mental Health Professional(s) (QMHP) or Qualified Substance Abuse Professional(s) (QSAP). Providers are using nurses to provide technical and medical support to the rest of the DM outreach team.
- Teams include trained **Wellness Coaches** who assist with maintaining consumer engagement and developing and achieving their health goals.
- Staff with good communication skills and/or some experience in outreach are typically selected to participate on the team.
- DM project coordinators hold weekly/biweekly meetings with the outreach team to address questions or concerns, investigate consumers who have not been found, share outreach strategies, and update the DM Consumer Status Report for DMH.
- Create friendly competition among staff to find, contact, and engage individuals in their DM cohort.
- Build the DM outreach team within the agency's current homeless/outreach/crisis teams.
- Add **Peer Specialists** to assist with outreach and engagement.
- Utilize QMHPs or QSAPs to complete assessments in the community as soon as the consumer agrees to enroll in services, or within just a few days of engagement. ***ADA DM*** outreach workers can begin to collect this information during their community visits. As long as a QSAP completes the assessment with the consumer and a licensed diagnostician conducts a face-to-face interview and renders a formal diagnosis once the individual is enrolled, this process is acceptable and will likely enhance consumer engagement during the outreach period.

Finding Individuals Assigned to the Provider

A challenge of the project is finding the individuals in the agency's assigned cohort. Providers have reported inaccurate or missing addresses and phone numbers. (Only 16 percent of these individuals had a phone number listed and even fewer were found to be valid.) In some cases, addresses were found to be those of abandoned buildings or vacant lots. Some success has been achieved by searching for addresses using a previous alias.

Here are some resources providers are using to assist in locating individuals in their DM cohort:

- ◆ Pharmacies – CyberAccess provides the contact information for pharmacies the individual has recently used to fill prescriptions. Providers can share the DM MO HealthNet (Missouri's Medicaid program) provider letter with pharmacies that may hesitate to give out patient information
- ◆ Local hospitals – CyberAccess displays ER visits and inpatient stays.
- ◆ Local primary care providers and other MO HealthNet providers – Providers can share the DM MO HealthNet provider letter with providers who hesitate to cooperate with the CMHC/ADA Provider for HIPAA compliancy reasons.
- ◆ Local FSD (Family Support Division) office – http://www.dss.mo.gov/fsd/office/
- ◆ Google and other Internet search engines
- ◆ Online social networks such as Facebook and Twitter
- ◆ Post office – Check to see if there is a forwarding address on file.
- ◆ Probation officers or police station
- ◆ DOC (Department of Corrections) Registry – https://web.mo.gov/doc/offSearchWeb/search.jsp
- ◆ CaseNet website to locate possible guardians or addresses
  www.courts.mo.gov/casenet/base/welcome.do

Eligibility for the Disease Management Program

Individuals in the DM cohort who are currently residing in another state, in a nursing home, or in jail **are ineligible** *for the project until their living situation changes or they are released from jail. These living situations make them ineligible to receive CPR or CSTAR services. Individuals residing in another state are ineligible for the project until they return to Missouri. CMHCs and CSTAR providers should check back with these individuals on a periodic basis to reevaluate their living situation.*

Individuals in the DM cohort who are found to be deceased should be reported to DMH for formal exclusion from the project. Individuals who are receiving hospice services or palliative care, who are on dialysis, or who have other questionable conditions should also be reported to DMH on a case-by-case basis for review and possible exclusion from the project. **This information should be reported via e-mail to Clive Woodward at clive.woodward@dmh.mo.gov.**

Medicaid Eligibility

The DM project targets active MO HealthNet recipients who have a mental health or substance use diagnosis and high-risk healthcare needs indicated in their Medicaid claims data. The purpose of the DM project is to provide care coordination and manage overall healthcare more effectively to improve patient health and reduce overall costs to the Missouri Medicaid program.

If individuals in the DM cohort are in spend down status, they ARE still Medicaid eligible and may be enrolled in services.

If DM individuals *currently enrolled* in CPR or CSTAR lose their Medicaid eligibility during their engagement in services, providers should continue to serve them as they would a non-DM consumer and assist in getting benefits reinstated, if eligible.

If outreach and engagement activities have not yet taken place and it is discovered that an individual is no longer Medicaid eligible, *you are not required* to enroll them in services as part of the DM project. You should report the participant's status to DMH as indicated below. If the individual is in a situation in which he/she can reclaim Medicaid benefits, providers may assist in that process and *bill for outreach* until they are enrolled in CPR or CSTAR.

You may check CyberAccess for any recent claims data and/or check current eligibility in Emomed (www.emomed.com). **Report Medicaid ineligibles to Clive Woodward clive.woodward@dmh.mo.gov for review and formal exclusion from the project.**

DMH Net *is a disease management initiative created to improve the lives of people in Missouri with mental illness and substance use disorders. This integrated model utilizes health information technology in combination with care management to coordinate and integrate behavioral and physical healthcare. The health information technology (HIT) tools used by DMH Net alerts providers of individuals who are in need of evidence-based treatments to effectively manage their diagnosed chronic conditions. Providers may use their nurse or other staff to implement DMH Net into the daily clinical operations of the agency.*

The following Health Information Technology used by DMH Net should be implemented in the DM project to identify, coordinate, and manage the health conditions of potential consumers:

CyberAccess

CyberAccess (Cyber) is a web-based, HIPAA compliant portal that enables users to view the complete medical and drug claim history for MO HealthNet fee-for-service participants. The claim history is extracted from paid claims and goes back approximately two years. Cyber provides valuable health information on prescriptions, procedures, diagnoses, and services that an individual has received from other MO HealthNet providers in the state.

With this tool, the end users are able to identify clinical issues that affect an individual's care. The application will display alert messages when they may be noncompliant with medication refills and/or treatment plans. The CyberAccess Patient Profile provides a summary of the individual's medical, behavioral, and medication claim history and has been helpful to the Disease Management team.

ProAct

NOTE: This tool is currently being used only for the DM 3700 and DMH Healthcare Home (HCH) initiatives. ADA DM providers will be notified and trained at such time it is determined the tool is relevant for their use.

ProAct Analytics provides abstraction, aggregation, analysis and interpretation of data, both prospectively and retrospectively, to aid clinical and financial risk analysis and management of a population. CMT integrates large volumes of disparate data (primarily behavioral pharmacy and services data, but including medical services and pharmacy data) and analyzes this convergence of information for the eligible population in respect to proportional financial risk, including adherence markers, gaps in care, substandard or inappropriate care, medical-behavioral co-morbid conditions that are associated with elevated cost burden, and chemical dependency or underlying addiction or substance dependency concerns that may be undermining overall health care and increasing costs.

ProAct provides secure, 24/7 access to prescriber and patient healthcare analytics by providing data on best practice for psychopharmacologic application relative to psychotropic and pain medicines called CMT's Quality Indicators™ (QIs) and Disease Management flags relative to gaps in care for chronic disease states most frequently associated with those suffering from mental illness. All data and data analytics are displayed for each patient in an Integrated Health Profile (IHP) for holistic health management. This data is used by care managers and care coordinators, provider relations departments, quality improvement staff and clinical and financial administrators to understand the patient/population needs and to direct intervention activity to obtain desired outcomes.

Disease Management Report

NOTE: This tool is currently being used only for the DM 3700 and DMH Healthcare Home (HCH) initiatives. ADA DM providers will be notified and trained at such time it is determined the tool is relevant for their use.

ProAct provides **Disease Management** reporting that flags patients with selected physical health conditions for whom appropriate screening and treatment activities appear to be lacking, based on a review of pharmacy and medical claims data. The report allows users to quickly identify patients for whom intervention is necessary in order to assure that medical needs are addressed, thus increasing patient health and reducing the costs associated with treating poorly managed conditions. The aggregated view allows users to quickly see which indicators are falling below targets.

The disease management indicators currently targeted:

1. *Adults with CAD with lipid level adequately controlled (LDL < 100 mg/dL).*
2. *Adults with hypertension with blood pressure adequately controlled (BP < 140/90 mmHg).*
3. *Adults with diabetes (type 1 or type 2) with lipid level adequately controlled (LDL < 100 mg/dL).*
4. *Adults with diabetes (type 1 or type 2) with blood pressure adequately controlled (BP < 140/90 mmHg).*
5. *Adults and Children with diabetes (type 1 or type 2) with blood sugar adequately controlled (A1 < 8.0%).*
6. *Adults and Children with asthma who were identified as having persistent asthma and were appropriate prescribed medication.*
7. *Adults and Children with documented body mass index between under 25.*
8. *Adults and Children reporting tobacco use.*
9. *Adults and Children with documented metabolic syndrome screening.*

Medication Adherence Report

NOTE: This tool is currently being used only for the DM 3700 and the DMH Healthcare Home initiatives. ADA DM providers will be notified and trained at such time it is determined the tool is relevant for their use.

ProAct provides adherence analytics to provide users with integral information regarding patients and their prescriptions, including their Medication Possession Ratio (MPR), a standard measure comparing fill dates to actual prescription regimen to determine gaps in care. Adherence data includes medication possession ratios (MPRs) for seven different classes of medications used to treat chronic conditions; including:

1. *Antipsychotics*
2. *Mood stabilizers*
3. *Diabetes medications*
4. *Anti-hypertensives*
5. *Cardiovascular medications*
6. *COPD medications*

Providers may begin the outreach process by mailing letters to all individuals in their agency's DM cohort who have an address available. *Sample templates will be placed on the ADA and CPS websites for agencies to adapt to their needs.* The letter may inform the individual of services available to them, offer an invitation to visit the agency, and let them know the agency outreach worker will be visiting them soon. A contact information sheet may also be included.

NOTE: Providers that have been involved in the DM project for the past few years have reported they receive minimal response from the letters and many are returned as undeliverable. The agency's DM outreach team typically follows up with phone calls (if a phone number was available) and finally a home visit*. Home visits* have been the most successful method of outreaching and engaging individuals in services. Some providers have been successful in teaming up with other community providers and meeting the individuals at their next scheduled doctor appointment.

Outreach staff can take the letter(s) with them on home visits as part of the provider's welcome packet. A **welcome packet** may include a contact information sheet, provider brochure, educational sheet on the individual's chronic disease(s), and a business card. The welcome packets are sometimes left with the pharmacy or physician's office to be shared with the individual at their next appointment. This strategy has also been used with pharmacies to reach out to homeless individuals.

Some providers have dedicated a workroom for the DM outreach team to research medical and drug claim histories on CyberAccess, review CIMOR for any previous DMH episode(s) of care, investigate/discuss individuals not yet located, and identify local providers and pharmacies used. They also post a map of the service area(s) and use pins to show where individuals in the DM cohort reside. They began attempting their home visits by assigning areas to the members of the outreach team. Other DM teams divided home visits by zip code.

NOTE: Outreach team members may choose to go in pairs on home visits in unsafe neighborhoods and areas relatively unknown. In these cases, it *IS ACCEPTABLE* for both individuals to bill for outreach services. Providers should be able to present the appropriate documentation that justifies this practice.

It is important that staff who enjoy this type of work and are experienced and properly trained in outreach and engagement strategies be assigned to this project.

Here are some outreach and engagement toolkits and brief descriptions of their content:

EFFECTIVE INVOLVEMENT IN MENTAL HEALTH SERVICES: THE ROLE OF ASSERTIVE OUTREACH AND THE VOLUNTARY SECTOR, by Rosie Davie, et al.
http://www.bristolmind.org.uk/files/docs/research/assertive-outreach-summary.pdf

Contains overarching themes such as:
- Participants want help focused on user priorities
- Building and maintaining relationships
- What helped and what was wanted
- What people widely experienced as unhelpful
- Recommendations such as:
  - Avoid labeling people as 'hard to engage'; this does not reflect the fact that most want help.
  - Follow user priorities and focus on practical support and quality of life issues.
  - Recognize the intrinsic importance of relationships with users and the need for consistent, flexible and reliable support that is available in the longer term.

ENGAGING PEOPLE WHO ARE HOMELESS WITH A MENTAL ILLNESS, by The Illinois Department of Human Services, Division of Mental health Homeless Action Committee
http://www.hacchicago.org/PDF/HAC_Engagement_Manual.pdf

Contains a checklist with ways to accommodate and communicate, with discussion points in different areas of engagement with those who are homeless.

MENTAL HEALTH OUTREACH: PROMISING PRACTICES IN RURAL AREAS, by David Lambert, et al. and the National Association for Rural Mental Health
http://www.narmh.org/publications/archives/REVISED_OUTREACH_PAPER.pdf

This is a helpful toolkit for any provider to review (not just those in rural areas). Contains overarching themes such as:
- General outreach to mental health populations
- Promising practices such as:
  - Decide what your goals are
  - Recruiting and training outreach workers

       o   Working with community partners
       o   Doing outreach: Finding and engaging people
       o   Dealing with access and distance
       o   Accommodating cultural issues
       o   Keeping outreach going
       o   Retaining and replacing staff

STRATEGIES FOR FINDING AND ENGAGING MEDICAID BENEFICIARIES FOR COMPLEX CARE MANAGEMENT, webinar presentation hosted by The Center of Health Care Strategies, Inc.
http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261169

Contains three presentations on outreach and engagement of similar projects:
- Washington Project Overview
- Persistence Pays Off: Employing a Team Approach to Find and Enroll High-Risk Beneficiaries
- Using Motivational Interviewing Skills to Enhance Care Manager Capacity

SAFETY MANUAL FOR COMMUNITY-BASED SERVICES, Haymarket Center reprinted this manual with permission by **Day Spring**
http://dmh.mo.gov/docs/ada/SafetyManualforComBasedSvs2.pdf

It is the highest priority for DMH and its contracted providers to keep all outreach team members safe when they reach out to unknown individuals and are visiting unknown locations. This toolkit highlights important safety tips for various situations such as:

- Approaching and entering the home
- In your car and to and from your car
- When walking
- Your consumer lives in an unsafe neighborhood
- Violent situations when they occur during your visit
- Angry parent who has just hurt his or her child
- You find child home, but no parent
- Immediate risk of suicide

Responses from individuals in the DM cohorts vary from, "Yes, sign me up!" to "No," Never," and "Don't come back!"

There are various reasons why individuals may refuse services from the agency, and some may ask skeptical questions pertaining to the program itself.

Here are some of the responses outreach teams have heard, and discussion points to consider when communicating with individuals in these circumstances:

Questions

- ◆ *"Why are you here? I don't need mental health/drug and alcohol services."*
- ◆ *"How did you get my address and/or phone number?"*
- ◆ *"Why was I selected to receive benefits from a mental health/substance use treatment center?"*

A good way to approach these kinds of questions is to remind the individual that the services provided by the agency are ***added benefits*** that MO HealthNet has made available to them with ***no extra cost*** or change to their current benefits. The agency has been provided with the individual's contact information because they have partnered with MO HealthNet to provide the individual with these additional benefits. It may also help to explain that the agency has qualified healthcare professionals (nurses, wellness coaches, case managers) equipped to help them manage all of their healthcare needs. Providers understand the importance of caring for the ***whole person*** in order to maintain a healthy lifestyle. Again, the outreach worker should review the DM letter sent to individuals in the cohort and explain the benefits in more detail.

No One is Home

- *Individual is not at home*
- *The individual doesn't answer the door, but you see the curtains move or someone peeking through the blinds as you drive away.*

If an individual is not at home or doesn't answer the door, try coming back on another day and/or at a different time of day. Leave a welcome packet by the door or mailbox with a personal note and/or business card to contact you. Continue to check back with the individual periodically or attempt to visit them at the pharmacy or at their next doctor appointment.

Maybe Later

- *"I'm not sure if I want services now, but I might later."*
- *"I could have used your services several months ago or a year ago, but now I have plenty of family support and/or I'm already receiving case management or other services from another provider."*

Be understanding and considerate of the individual's current situation and use this opportunity to establish a good rapport with them. Make sure to leave a welcome packet and business card and invite them to contact you anytime. Continue to check back with individuals to visit and reevaluate their situation. ***In the meantime, and as a courtesy, you may want to send periodic educational materials concerning healthy lifestyle choices or managing their chronic disease(s). This will also help keep the lines of communication open.***

Hard Refusals

- ***"NO!"*** *These are considered "hard refusals" with the individual being adamant that they are not, and never will be, interested in any kind of service. Hard refusals have also been known to result in a slam of the front door in your face and/or threat such as, the next time you will meet their dog (or worse).*

Hard refusals are the most difficult to handle and can be discouraging, if not sometimes scary. Always take a safe approach when communicating and further outreaching to these individuals. Keep in mind that it may not have been a good time for them at your initial visit and you may find them to be more receptive later. However, use your best judgment when deciding the next course of action. Depending on the degree in which they said, "No," you may try to call, send a follow-up letter, or evaluate whether to attempt another home visit in a month or two.

ALWAYS MAKE SURE YOU ARE SAFE IN YOUR OUTREACH EFFORTS!

Consumer Enrollment

For individuals who decide to enroll and receive services from the agency, the following steps should be taken:

DM 3700 – A QMHP may complete the CPR assessment in the community (to reduce the hassle of "no show" appointments) or schedule an appointment within a few days of initial contact. The CPS Adult Status Report must be completed within 30 days of enrollment and the Metabolic Screening must be completed within 180 days of enrollment. Some providers have their outreach team members call to schedule a doctor appointment for the individual within seven days and they do this before leaving the individual's home.

ADA DM – It is recognized that individuals involved in the ADA DM initiative have complex behavioral and physical health needs. Their symptoms and life experiences make them particularly hard to engage and retain in any type of service program. While the conduit through which these individuals can gain access to needed services and care coordination is the CSTAR program, some current CSTAR rules do not fit well with a disease management philosophy.

For the ADA DM population ONLY, the timeline for completion of the initial assessment and treatment plan will be extended to *30 days from the date of CSTAR admission*. Providers will be able to enter the essential CIMOR data in order to assign the individual to a program/service category and bill for services while the assessment and treatment plan is being developed. This policy is *ONLY* for ADA DM consumers who are closely tracked in the system.

A QSAP may begin or complete the assessment in the community and schedule an appointment for a face-to-face interview with a licensed diagnostician who will render a formal diagnosis. It is not anticipated that QSAPs will be involved in outreach activities to a high degree; therefore, the outreach staff can begin to collect the required information during their visits in the community if this process is amenable to the individual. A QSAP must complete the assessment with the consumer and a licensed diagnostician must conduct a face-to-face interview and render a formal diagnosis once the consumer is enrolled. *All other data collection and updates (TEDS) remain the same in CIMOR for ADA DM consumers.*

NOTE: At such time the Division of Behavioral Health makes a determination as to a standard medical screening or collection of other data elements, providers will be notified and appropriately trained prior to implementation.

Our case manager, "Sally", enrolled a DM individual who has been in two bad accidents and has constant, severe pain. He was going to have a procedure in which a device would be implanted into his back – the procedure would have cost $300,000. Sally went to appointments with him, and after getting a second opinion, the individual realized that the surgery posed more risks than potential good and decided against it. Sally also worked with him on his disability, which he was awarded, so he is now going to buy some kind of used car with his back pay and will no longer rely on Medicaid transportation.

"Sally" has started working with a woman who was a "frequent flyer" to emergency rooms and doctor offices. The individual agreed to have Sally meet her doctors, has started seeing our psychiatrist and has not gone to the ER or another doctor once since enrollment. I think this is in large part because she knows that she can call Sally, and she also now has some hope that her situation can change.

We are currently working with a DM individual who has been denied disability three times, and is appealing for a fourth. She had never read her denial letter because she did not understand the terminology. Her case manager was able to help her understand the letter, and together they found many discrepancies that were not in the individual's favor. The letter stated that the individual had not followed up with depression or HIV treatment since 2008. The case manager was able to link the individual to Direct Inform in order to print off all Medicaid claims since 2008 to show her lawyer. We are hoping that this will be what it takes to win her disability case.

One of our DM individuals was homeless when he was found by the outreach case manager. The individual is a severe alcoholic, and is also dependent on pain killers. He has severe health conditions, and also has a pacemaker. This individual entered the emergency room almost weekly (if not more often) after being found by police intoxicated in public, or self-admitted after a severe episode of drinking that led to chest pain. He also had a warrant out for his arrest for an instance such as this. Since working with his case manager, the individual has successfully completed inpatient treatment and continues to go to outpatient treatment on a regular basis. He has also secured permanent housing. Although there is still a lot of work to do, progress has been made. The local hospital has communicated that they have noticed a dramatic decrease in the individual's ER visits and hospital stays. He has also completed the community services needed to remove the warrant.

One of our outreach case managers went to visit the home of a DM individual. A woman answered, and the case manager asked to speak with "Charlie." The woman was Charlie's mother, and she said her son had committed suicide only a month ago and had desperately needed the help – had we come sooner. This was a bitter reminder of why we are searching to serve those in this delicate population.

The second DM individual that we met during outreach had just been released from our local stress unit the same week, and has a significant history of self-admitting himself there. He is severely mentally ill, is dependent upon prescription pills and alcohol and was a victim of physical and verbal abuse throughout his childhood. It makes sense that the stress center is a respite for him as he is sober, medicated and cared for there. We found the individual living with his childhood abuser – his father. His father constantly berates him for taking prescribed medication for his mental illness and for abusing pills and alcohol. The individual also blames himself for his brother's suicide, and has never received therapy to cope with this painful experience; therefore, he self-medicates to escape his reality. He does not fill his psychotropic medication after being released from inpatient hospitalizations because he'd rather spend the co-payment on alcohol before returning home with his father. The individual was hospitalized the week after we enrolled him, and the evening of his release he was drunk driving and committed a hit-and-run – he was hospitalized yet again. We immediately began coordinating care with his probation officer and the hospital. His case manager completed the necessary paperwork to obtain funding in order to place him in a long-term treatment facility, as he has been in short-term treatment facilities to no avail. We are happy to report that he is now sober and thriving!

Tara Crawford, tara.crawford@dmh.mo.gov, 573.751.8124
Debbie McBaine, debbie.mcbaine@dmh.mo.gov, 573.522.3308
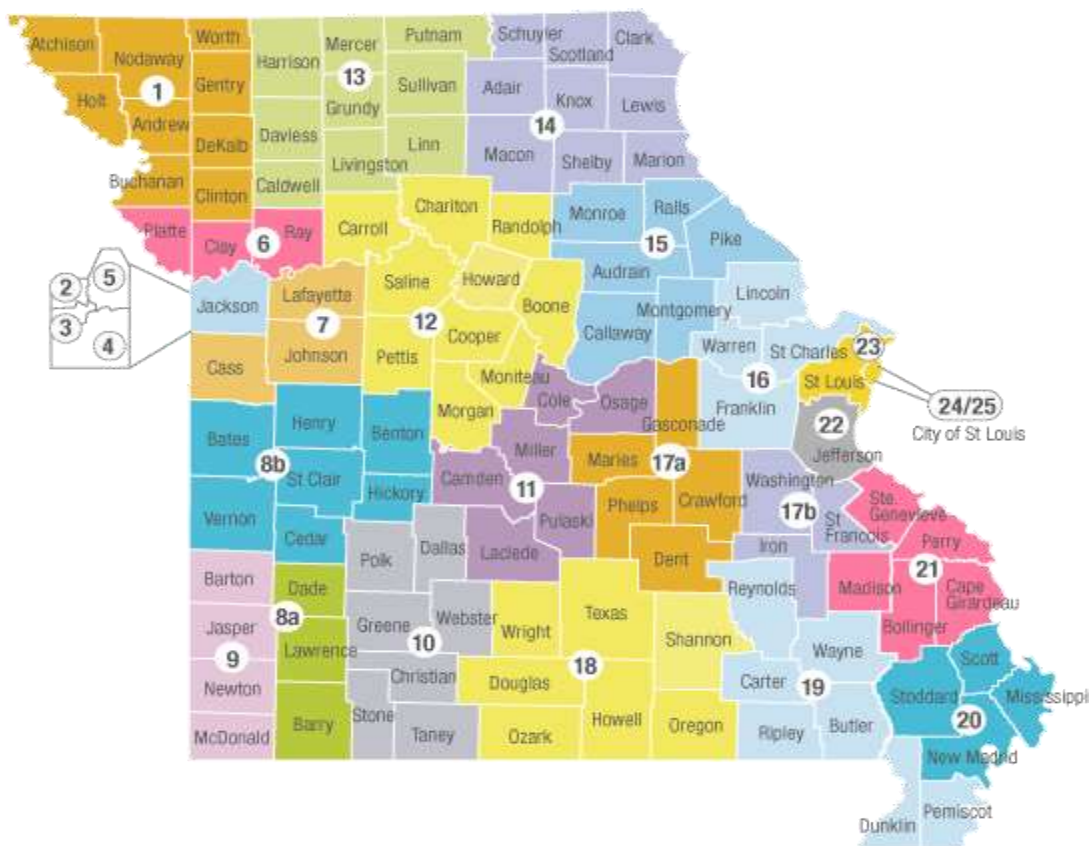Clive Woodward, clive.woodward@dmh.mo.gov, 573.751.9736

Brent McGinty, bmcginty@mocmhc.org, 573.634.4626
Rachelle Glavin, rglavin@mocmhc.org, 573.634.4626

Missouri Service Areas

Contact List for DMH Administrative Agents and Affiliates in MO Service Areas
http://dmh.mo.gov/mentalillness/org/county.htm

Contact list for CSTAR Providers: CSTAR Provider Directory.pdf

MISSOURI DEPARTMENT OF MENTAL HEALTH
DIVISION OF ALCOHOL AND DRUG ABUSE
REGIONAL OFFICES AND SERVICE AREAS

WESTERN REGION
Denise Norbury, REO, Divisions of ADA and CPS
ADA Western Regional Office:
2600 East 12th Street
Kansas City, MO 64127
816-482-5770
Fax: 816-482-5774

SOUTHWEST REGION
Denise Norbury, REO, Divisions of ADA and CPS
ADA Southwest Regional Office:
149 Park Central Square, Suite 910
Springfield, MO 65806
417-895-6328
Fax: 417-895-6329

CENTRAL REGION
Jodi Haupt, REO, Divisions of ADA and CPS
Missouri Department of Mental Health
1706 East Elm Street, P.O. Box 687
Jefferson City, MO 65102
573-751-4942
Fax: 573-751-7814

SOUTHEAST
Julie Inman, REO, Divisions of ADA and CPS
ADA Southeast Regional Office:
105 Fairgrounds Road
Rolla, MO 65402
573-368-2297
Fax: 573-368-2396

EASTERN REGION
Laurent Javois, REO, Divisions of ADA and CPS
ADA Eastern Regional Office:
Saint Louis Psychiatric Rehabilitation
  Center, Dome Building
5400 Arsenal, Mail Stop A-419, 4th Floor
Saint Louis, MO 63139
314-877-0370
Fax: 314-877-0392

MAP LEGEND

Revised: August 31, 2012
Source: ArcGISSmith\ADAregSAcontact.mxd

Maps website:
http://dmh.mo.gov/ada/resourcemapsinfo.htm

ADA REGIONAL OFFICES	
ADA/CPS REGION BOUNDARIES	
ADA SERVICE AREA BOUNDARIES	
COUNTY BOUNDARIES	
	WESTERN REGION
	CENTRAL REGION
	EASTERN REGION
	SOUTHWEST REGION
	SOUTHEAST REGION

Disease Management

MISSOURI DEPARTMENT OF MENTAL HEALTH

Providers should ensure that all staff involved in the DM project have read the following documents. As cited at the beginning of this toolkit, these documents can be downloaded from the respective behavioral health web pages.

◆ Project Policies and Procedures

◆ Frequently Asked Questions

◆ DM Provider Contact Lists

◆ Sample Letters (Templates) to Consumers

◆ Safety Manual for Community Based Services

◆ CPS Adult Status Report

◆ Metabolic Syndrome Screening Policy Memo

◆ Metabolic Syndrome Screening and Monitoring Tool

◆ Metabolic Screening Procedure Codes

◆ Metabolic Screening Provider Letter

◆ Metabolic Screening Supplemental Templates

◆ "How to" Guide for Locating Pharmacy Information in CyberAccess

◆ DMH Net Overview and Role of Nurse Liaison

◆ DMH Net: MO HealthNet Resources